Opioid Psychiatry

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Disclosure

With respect to the following presentation, there has been no relevant (direct or indirect) financial relationship between the party listed above (and/or spouse/partner) and any for-profit company within the past 24 months which could be considered to pose a conflict of interest.
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The views presented herein are my own and do not reflect the position or policy of the National Institutes of Health, the Public Health Service, or the Department of Health and Human Services.

So, it’s complicated...

Most of our discussion of opioids is focused on what they do via \( \mu \) receptors.
\( \sigma \) receptor agents have mood effects.

Novel therapeutics to treat depression include \( \delta \) receptor agonists.

- Increase expression of brain-derived neurotrophic factor (BDNF)
- Stimulatory (Epileptogenic)
- Improvements in animal model (forced swim)
- Early human trials show promise...

"Everything should be made as simple as possible, but not simpler."

- Albert Einstein
Background

Opioids and psychotropics have large prescription drug market shares.

Patients with comorbid diagnoses (and taking both) are the rule, not the exception.

In general having one is a risk for the other.

Over 30% of psychiatric patients have a substance abuse disorder (though often missed).

Every opioid abuser has a psychiatric illness and over 90% have at least one additional dx.

43% of the variance in predicting opioid misuse is attributable to psychological factors.

"Religion is the opiate of the masses."
- Karl Marx

"Opiates are a religion for the masses."
- Dr. Frustrated
“Religion is the opiate of the masses.”
- Karl Marx

“Opiates are a religion for the masses.”
- Dr. Frustrated

“Masses of opiates are my religion.”
- Your Next Patient

Case 1
Bright 22 y/o recent college graduate
Anxiety and “eating” issues in school, but excelled while partying like others
Abused as a child by uncle
Antidepressant medications since teen
Sees counselor, psychiatrist, and family doc—the latter refers to rheum for multiple MS pain problems after patient has conflicts in first job...

Case 2
46 y/o blue collar high school grad
Happy, rough & tumble childhood
Smoked on & off, quit when kids born
Overweight with GERD
Slipped and fell on ice at construction site while carrying dry wall
MRI with some “disc changes” and evidence of “mild bony abnormalities”
Which of these patients is likely to receive opioid analgesics safely and effectively?

Efficacy

Acutely, both of these patients would likely report relief with a short course of opioids.

Predictors of inefficacy include:
- Active substance abuse disorder
- Current, severe mood disorder
- Post traumatic stress disorder
- Central nervous system disease
- Recalling what pain is, we expect relief...

Acute Response

Somatic symptoms
- Tissue damage → nociception & experience

Affective symptoms
- Anxiety, fear, irritability, anger, lability, ...

Evidence of endogenous opioid hypofunction in patients with personality disorder showcasing these symptoms
Chronic Pain Conditions

In general, sound research shows no functional benefit of opioids over other interventions for chronic, non-cancer pain.

Back Pain
- Possible short term efficacy, doubtful long term benefit, aberrant use in up to ¼ of patients.

Fibromyalgia
- Possible short term efficacy (anecdotally diminished) doubtfull long term benefit, aberrant use and exacerbation of mental illness common.

Your Brain on Chronic Opioids

Slowed cognition
Impaired memory
Delayed reaction time
Impaired attention
Decreased motivation
Depression
Rebound anxiety

Safety (Addiction)

Substance abuse history (incl. tobacco)
First degree family history of EtOH, illicit drugs
History of suffering abuse
High comorbidity major mental illnesses:
  - PTSD
  - Bipolar Disorder
  - Schizophrenia
  - ADHD (Untreated/Active)
  - Anxiety disorders (Untreated/Active)
Addictive Personality?

Disorders
  Antisocial (Conduct disorder in youth)
  Borderline
  Narcissistic, Histrionic, Obsessive Compulsive

Traits:
  Neuroticism (tendency to think negatively)
  Less conscientious
  Impatient
  Impulsive

SOAPP
Screener and Opioid Assessment for Patients with Pain

24-item self report
Blends personality & behavior
Likert scales
Total, above a threshold, correlates with abuse potential
Remains inferior to clinical psychology
Case Patients

<table>
<thead>
<tr>
<th>22 y/o Female</th>
<th>46 y/o Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>High psychopathology</td>
<td>Mentally well</td>
</tr>
<tr>
<td>Significant, recent drugs</td>
<td>Remote tobacco</td>
</tr>
<tr>
<td>History of abuse</td>
<td>Stable childhood</td>
</tr>
<tr>
<td>Neurotic</td>
<td>Grounded</td>
</tr>
<tr>
<td>Personality concerns</td>
<td>No interpersonal issues</td>
</tr>
<tr>
<td>ORT / SOAPP elevated</td>
<td>ORT / SOAPP low risk</td>
</tr>
</tbody>
</table>

Patient #2 with, perhaps, the more pathologically identifiable lesion...

But if the barn door is already open...

...where do you locate the horse (or the horse pills, or the smack, or the oxys...)?

COMM
Current Opioid Misuse Measure

17-item self report
Assesses symptoms & behavior
Likert scales
Total, above a threshold, correlates with misuse likelihood
Almost 80% sensitive, but less specific
MMPI
Minnesota Multiphasic Personality Inventory
567-item self report (True/False)
70 years of study
Numerous report scales
Less specific for just substance misuse, but sensitive and detailed
Almost ¾ of chronic opioid patients display high levels of disability

Case Patients
22 y/o Female 
Age 11 Anxiety NOS
Age 16 PTSD
Age 18 Eating Disorder
Age 19 Major depression
Age 21 Polysubstance abuse
Age 25 ADHD
Age 27 Somatoform disorder
Age 32 Borderline PD
Age 37 Adjustment d/o
|
46 y/o Male
Age 40 Major depression
Age 51 Anxiety NOS
Age 52 Alcohol abuse
Age 57 Pain Disorder
Age 58 Obesity, Type II DM
Age 59 Mild cognitive impair.
Age 60 Partner relational prob
Age 61 Adjustment d/o
|

Suicide
Opioid patients have 20-fold rate
Complicated by accidental vs. purposeful
Growing problem
Increased availability  Narrow safety margin
9.4 % of purposeful overdoses in ToxIC Registry
13.6 % (89 of 655) of an inpatient tox sample involved in greatest morbidity, and 2 of 5 deaths
Hydrocodone, Oxycodone, Tramadol
Dual Diagnosis

Substance abuse primary
Even if one believes that addiction points to deeper psychopathology, that target can be hard to identify and treat in such patients.

Mood / anxiety primary
Substance use may be problematic, even dangerous, but other issues may be at root.

Unclear or acutely intertwined
Arguably, best addressed together.

History
Personality
Comorbidity

Acute Benefit

Chronic Benefit

Yes
No
Summary

Pre-existing substance use diagnoses are obvious risk factors for dangerous misuse.

Other common Axis I conditions like depression and anxiety are less practically helpful:

  - High comorbidity, and non-specificity
  - Bipolar disorder and schizophrenia perhaps...

Some personality traits and disorders are valuable:

  - Conduct/Antisocial and Borderline
  - Impulsivity, irresponsibility, and lability

Screening instruments (SOAPP, ORT), or ideally a psychological evaluation may be employed.

And if it gets out of hand...

The patient is toxic, withdrawing, or mentally destabilized...

Or there are other signs that life and relationships are suffering, while pill counts are changing...

Take advantage of the consultative role:

  - To stand apart
  - To obtain perspective
  - To (re)-assess risks/benefits
  - To demand clarity

"Listen to everything; believe nothing."

"Those who have the privilege to know have the duty to act."

- Albert Einstein
References

3. Date, Pain Practitioner 2009; 10:20-34.